

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 110-6

## CERTIFICATE OF DEATH

12704



Reg. Dist. No. 290

### 1. PLACE OF DEATH:

County Talbot  
City or town Easton  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? all of life  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot  
City or town Easton  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Harvey Vernon Andrew

### 3. (b) Social Security Number

none

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Baby

8.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5: 1945

8. AGE: Years Months Days If less than one day  
5 1 hrs. min.

9. Birthplace Easton, Talbot Co., Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name O. N. Andrew

13. Birthplace Easton, Md.

14. Maiden name Elsie Nahn

15. Birthplace Cordova, Md.

16. Informant O. N. Andrew

Address Easton, Md.

17. Burial Date thereof Dec. 7, 45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Spring Hill Cemetery

Location Easton, Md.

18. Funeral director John D. Williams

Address Easton, Md.

19. 12/5 19 45 H. D. Neer  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6 19 45 at 2:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 20th 19 45, to Dec. 5th 19 45, and that I last saw him alive on Dec. 5th 19 45.

Immediate cause of death Pleurisy with effusion

Due to Broncho pneumonia

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William S. Symons M. D. or other  
Address Easton Md. Date signed Dec 6/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 11 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1210

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH: Talbot  
County.....  
Easton  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?.....  
Hospital, institution, or street address where death occurred:  
.....  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State MD. County Talbot  
City or town Easton  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. ....  
(If rural, give LOCATION)  
2.(a) If veteran, name war .....

3. (a) FULL NAME S. Augusta Callahan 3. (b) Social Security Number L

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow  
6. (b) Name of husband or wife L. A. Callahan  
(If deceased, write deceased)

7. Birth date of deceased (mo., day, yr.) March 20, 1874 6. (c) If alive, give age ..... years

8. AGE: Years 71 Months 8 Days 16 If less than one day  
..... hrs. .... min.

9. Birthplace Sumner Co. Md.  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

12. Name Samuel McGraw

13. Birthplace Sumner Co. Md.

14. Maiden name Lucinda McGraw

15. Birthplace Maryland

16. Informant Lucinda Callahan (Daughter)

Address Franklin Ave., Easton, Md.

17. Buried Date thereof Dec. 20, 1945  
(Burial, cremation, or removal. Whole? (month) (day) (year))

Cemetery or crematory Spring Hill

Location Easton, Md.

18. Funeral director Albin Cook

Address Easton, Md.

19. 12/20 19 45 N. H. Morris  
(Date read by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 18 - 1945 at 3:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 16 19 45 to Dec 18 19 45

and that I last saw her alive on Dec - 16 - 1945

Immediate cause of death..... DURATION

Chronic Interstitial nephritis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE W. Henry Fisher M. D. or other

Address Curtisville Md Date signed 12/18-45

RECEIVED

DEC 26 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County Talbot  
 City or town Caston Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
Memorial Hospital  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot  
 City or town Caston Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Dover Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Alexander Dyatt

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mulla Dyatt

6. (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) July 7, 1895

8. AGE: Years 50 Months 7 Days 23 If less than one day  
 hrs. min.

9. Birthplace Caston, Md  
 (Town, county, and state)

10. Usual occupation State Nurse

11. Industry or business

12. Name Edward Dyatt

13. Birthplace Md.

14. Maiden name Ella May Page

15. Birthplace Md.

16. Informant Mulla Dyatt

Address Caston, Md

17. Burial Date thereof 12/24/45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Spring Hill

Location Caston, Md.

18. Funeral director W. S. Seymour

Address Caston, Md.

19. 12/23 45 N. H. Merriam  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 1945 at 2:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 18 1945 to Dec. 21 1945

and that I last saw him alive on Dec. 21 1945

Immediate cause of death Pneumonia (lobar) DURATION 5 days

Due to Alcoholism and exposure 4 wks.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations. Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE W. S. Seymour M. D. or other 12/24/45

Address Caston Md Date signed

RECEIVED

JAN 3 1946

BUREAU V A



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

## CERTIFICATE OF DEATH

Reg. Dist. No. 127 290

1. PLACE OF DEATH: Easton, Talbot Co. MarylandCounty Easton, MdCity or town Easton, Md  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County TalbotCity or town Easton  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME

Rosa Elliott

3. (b) Social Security Number \_\_\_\_\_

4. Sex

Female

5. Color or race

C

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) June 18, 1908

8. AGE: Years Months Days If less than one day

37 June 18 \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Easton Talbot Co. Maryland  
(Town, county, and state)10. Usual occupation Labourer

11. Industry or business \_\_\_\_\_

12. Name William Elliott13. Birthplace Michigan14. Maiden name Fannie Biggs15. Birthplace Virginia16. Informant Fannie MillsAddress 1510 N. Fifth Phila. Penna17. Burial Date thereof Dec. 29, 45

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory EastonLocation Easton18. Funeral director Earl W StaffordAddress Easton Maryland19. 12/29 19 45 N.H. Neer

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 26 December 1945 at 7:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Never saw her alive to \_\_\_\_\_ 19 \_\_\_\_\_and that I last saw her saw her half hour after death alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death \_\_\_\_\_

Pulmonary tuberculosis DURATION 1 year

(History from Health Dept)

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. J. Cox M. D. or otherAddress Easton Md Date signed 12/29/45

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
JAN 3 1946  
BUREAU V.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 920

## CERTIFICATE OF DEATH

Reg. Dist. No. 12708 294

## 1. PLACE OF DEATH:

County Talbot  
 City or town Sherwood (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Fifteen years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Talbot  
 City or town Sherwood (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

John Gaskins

## 3. (b) Social Security Number

216 12 1450

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) August 1, 1871 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 74 Months 4 Days 23 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Unknown  
 (Town, county, and state)

10. Usual occupation Oyster Shucker11. Industry or business Packing Mouse12. Name Unknown13. Birthplace II14. Maiden name II15. Birthplace II16. Informant Talbot County Welfare BoardAddress Easton Md.

17. Burial Date thereof 12 28 45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory CemeteryLocation Sherwood Md.18. Funeral director J/ Norman MarshallAddress St. Michaels, Md.

19. Dec. 27<sup>th</sup> 19 45 Anna P. Thomas  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1945 at 4A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

\_\_\_\_\_ 19 40 to Dec 24 45 19 45and that I last saw him alive on Nov 19 45 19 45Immediate cause of death Tracheal Heart Disease DURATION 4 yrsFound on inspectionDue to Heart suddenly

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John Marshall M. D. or otherAddress Talbot Date signed Dec 27 45

RECEIVED  
JAN 2 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

Reg. Dist. No. 12709 290

## 1. PLACE OF DEATH:

County TackettCity or town Easton  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 years  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County TackettCity or town Easton  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Charles Gibson

## 3. (b) Social Security Number

4. Sex

M.

5. Color or race

C.

6. (a) Single, married, widowed, or divorced

Decedent.

8. (b) Name of husband or wife

Clara Hughes

8. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of

deceased (mo., day, yr.)

Not known

8. AGE:

Years

Months

Days

If less than one day

80

hrs.

min.

9. Birthplace

Easton, Tackett, Md.  
(Town, county, and state)

10. Usual occupation

Unable to work

11. Industry or business

George Gibson

FATHER

12. Name

George Gibson

13. Birthplace

Md.

14. Maiden name

Mariline Conner

15. Birthplace

Md.

16. Informant

Stella Dargatzis

Address

1111 South St. Easton, Md.

17.

(Burial, cremation, or removal) (place)

Date thereat

Dec 23, 1945  
(month) (day) (year)

Cemetery or crematory

Richard Cemetery

Location

Easton, Md.

18. Funeral director

Rich Bank

Address

Easton, Md.

19.

(Date rec'd by registrar)

12/22N-H. Neer

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21, 1945 at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 20, 1945 to Dec 21, 1945and that I last saw him alive on Oct 7, 1945

Immediate cause of death

Acute coronary disease

DURATION

Due to

Chronic Rheumatoid3 wks

Due to

Total Blindness

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE

St. Michael's

M. D. or other

Address

122345

RECEIVED

DEC 28 1945

BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12710

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County HarborCity or town Easton  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 1/2 yrs.

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 4 1/2 hrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County CarolineCity or town Greensboro  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION) ✓

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Holland - Mrs. Lydia

## 3. (b) Social Security Number

4. Sex Female5. Color or race w.

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife John Holland7. Birth date of deceased (mo., day, yr.) Dec. 8, 1890

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 55 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Greensboro Md.  
(Town, county, and state)10. Usual occupation H.W.

11. Industry or business

12. Name Wm. Thomas13. Birthplace Greensboro Md.14. Maiden name Mary Hammond15. Birthplace Greensboro Md.16. Informant James L. HollandAddress Wilmington Del.17. Burial (Burial, cremation, or removal? Which?) Date thereof 12/26/45  
(month) (day) (year)Cemetery or crematory Greensboro, Md.Location Greensboro, Md.18. Funeral director H. B. RawlingsAddress Greensboro, Md.19. 12/25 19 45 N. H. Neer  
(Date read by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23/ 19 45, at 1042 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/23/ 19 45 to 12/23/ 19 45and that I last saw him alive on 12/23/45 19 45

Immediate cause of death \_\_\_\_\_

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## DURATION

12 hours10 yrs.

Other conditions \_\_\_\_\_

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\_\_\_\_\_

22. SIGNATURE

J. E. Cox M.D.Address Easton Md.Date signed 12/24/45

RECEIVED

DEC 29 1945

BUREAU V. R.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

12711

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County Eastern, Md.City or town Boston, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

few hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne'sCity or town Grasonville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Alvin Johnson

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

Black

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Hopkins Johnson

7. Birth date of

deceased (mo., day, yr.)

Oct. 15, 1892

6.(c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

53214

hrs.

min.

9. Birthplace

Bethesda Co. Va.  
(Town, county, and state)

10. Usual occupation

Oyster Shuckler

11. Industry or business

FATHER

12. Name

Albert Johnson

13. Birthplace

Va.

MOTHER

14. Maiden name

Rosa Toliver

15. Birthplace

Va.

16. Informant

Address

Hopkins Johnson  
Grasonville, Md.

17.

Burial  
(Burial, cremation, or removal. Which?)

Date thereof

1/2/45  
(month) (day) (year)

Cemetery or crematory

Harlock Md.

Location

Harlock Md.

18. Funeral director

Address

Chas. D. Bellinger  
Boston Md.

19.

12/30  
(Date rec'd by registrar)

19

45W. H. Norris

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 1945 at 8:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 29 1945 to Dec. 29 1945and that I last saw him alive on Dec. 29 1945

Immediate cause of death

Chronic myocarditis

DURATION

?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE

Louis (Phat) M. D. Bellinger  
Boston Md.  
M. D. or other \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 1-1-46

RECEIVED  
JAN 10 1946  
BUREAU V.F.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 89a

## CERTIFICATE OF DEATH

12712

Reg. Dist. No. 291

## 1. PLACE OF DEATH:

County Talbot  
 City or town Bogman, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? life  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Talbot  
 City or town Bogman  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

William J. Jones

## 3. (b) Social Security Number

220-16-7659

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

Single

## 8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Oct 3, 1878  
 8. (c) If alive, give age..... years

## 8. AGE:

Years	Months	Days	If less than one day
<u>67</u>	<u>2</u>	<u>21</u>	.....hrs. ....min.

## 9. Birthplace.....

Bogman, Md.  
(Town, county, and state)

## 10. Usual occupation.....

Welder

## 11. Industry or business.....

## FATHER

## 12. Name.....

James Jones

## 13. Birthplace.....

Bogman, Md.

## 14. Maiden name.....

Elizah Jones

## 15. Birthplace.....

Bogman, Md.

## 16. Informant.....

Mrs. Eliza Jones

## Address.....

Bogman, Md.

## 17. Burial

Date thereof Dec 28/1945  
(Burial, cremation, or removal. Which) (month) (day) (year)

## Cemetery or crematory.....

Cemetery

## Location.....

Bogman, Md.

## 18. Funeral director.....

Burnham & Harrison

## Address.....

S. Michaels, Md.

## 19. Date rec'd by registrar

Dec 28/45  
(Date rec'd by registrar) 19 45 John Hurwicks  
Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec 24 19 45, at 8 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 1 19 45 to Dec 24 19 45  
 and that I last saw him alive on Dec 24 19 45

Immediate cause of death.....

DURATION

Cerebral hemorrhage  
Arterio Sclerosis

2 hrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE.....

J. Hurwicks  
S. Michaels, Md. Date signed 12/24/45

*Ernest*

RECEIVED  
JAN 7 1946  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County TalbotCity or town Easton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital - Easton, Md

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Easton  
(If outside city or town limits, write RURAL and give nearest town)Street No. Memorial Hospital  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Albert Lee Mc Kee, Jr

## 3. (b) Social Security Number

4. Sex Male5. Color or race W

B.(a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Dec 13 1945

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

5

hrs.

min.

9. Birthplace

Easton, Talbot, Md  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Albert Lee Mc Kee

13. Birthplace

Delaware

MOTHER

14. Maiden name

Corelyn Frances Clarkson

15. Birthplace

Easton

16. Informant

Corelyn Frances Mc Kee

Address

Easton Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

12/20/45  
(month) (day) (year)

Cemetery or crematory

Spring Hill

Location

Easton Md

18. Funeral director

Carl W. Stoffer

Address

Easton Md

19.

(Date rec'd by registrar)

19

45M.D. Keener

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 1945, at 8 30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 13 1945 to Dec 19 1945and that I last saw him alive on Dec 19 - 8:30 am 1945

Immediate cause of death

Myocardial infarction

DURATION

Due to

Patent Foramen ovale

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. John Baker M.D.  
M. D. or other

Address

EastonDate signed 12-20-45

RECEIVED

DEC 26 1945

BUREAU V S.



Evidence for change of age of deceased is shown on MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore

FILM No. I 00 FEB 7 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot  
City or town Easton, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 49 days  
Hospital, institution, or street address where death occurred:  
Memorial Hospital  
How long in hospital or institution? 49 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Talbot  
City or town Easton  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME

Mrs. Lula Mills

3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife James Mills

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1894 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 61 Months 6-2 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Essex Co. Va.  
(Town, county, and state)

10. Usual occupation H.W.

11. Industry or business \_\_\_\_\_

12. Name Gen. Crow

13. Birthplace Essex Co. Va.

14. Maiden name Lula V. Fagg

15. Birthplace Essex Co. Va.

16. Informant James H. Mills

Address Oxford Md.

17. Buried Date thereof 12/25/45  
(Burial, cremation or removal. Which?) (month) (day) (year)

Cemetery or crematory Oxford Md.

Location Oxford, Md.

18. Funeral director Wm. E. H. H. H.

Address Easton Md.

19. 12/26 19 45 M. H. H. H.  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25 19 45 at 5-4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/19 to 12/25 19 45  
and that I last saw him alive on 12/25 19 45

Immediate cause of death adverse - Carcinoma of  
of Gall Bladder

Due to \_\_\_\_\_

Other conditions Pertussis agitata

(Include pregnancy within 3 months of death)

Major findings of operation Indurated Mass

involving R.B. Colon (Sigmoid) Date of op. 12/20/45

Autopsy results Not obtained

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Wm. A. H. H. H.

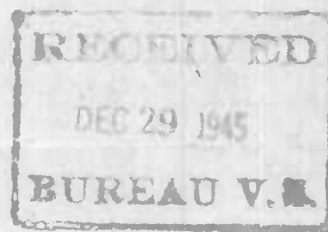
Address Easton Md. M. D. or other \_\_\_\_\_

Date signed 12/26/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County TalbotCity or town Easton  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 3 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Easton  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Viola Lee Maylor

## 3. (b) Social Security Number

4. Sex female5. Color or race white6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Bruce Maylor7. Birth date of deceased (mo., day, yr.) Sept. 28, 1906

8. AGE: Years Months Days If less than one day

79 2 13 hrs. min.9. Birthplace Lynchburg Va.  
(Town, county, and state)10. Usual occupation 4th

11. Industry or business

12. Name James Clark13. Birthplace Va.14. Maiden name Elija Booker15. Birthplace Va.18. Informant Bruce MaylorAddress Belleme Ind17. Cremation Date thereof Dec 13 45  
(Burial, cremation, or removal. Write (month) (day) (year))Cemetery or crematory Fort LincolnLocation Madanburg Ind18. Funeral director John P. WilliamsAddress Madanburg Ind19. 2/12 19 45 N.H. Neering  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11 December 1945 at 12:14 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 December 1945 to 11 December 1945 and that I last saw him alive on 11 December 1945

Immediate cause of death \_\_\_\_\_

UremiaDUE TO acute interstitial obstruction 8 days

DUE TO \_\_\_\_\_

DUE TO \_\_\_\_\_

DUE TO \_\_\_\_\_

DUE TO \_\_\_\_\_

DUE TO \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations Post-operative adhesionAutopsy results \_\_\_\_\_ Date of op. 12 December 45

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. Tyler Baker M.D.Address Easton Maryland M. D. or other \_\_\_\_\_Date signed 2-12-45

RECEIVED

DEC 26 1945

BUREAU V A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 298

## 1. PLACE OF DEATH:

County Talbot CountyCity or town Easton, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

M. Memorial Hospital

How long in hospital or institution?

4

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Delaware CountyCity or town Wilmington  
(If outside city or town limits, write RURAL and give nearest town)Street No. 5907 Governor Price Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

John T. Newlin4. Sex M 5. Color or race W. 6.(a) Single, married, widowed, or divorced Married6.(b) Name of ~~husband~~ or wife Anna T. Newlin7. Birth date of deceased (mo., day, yr.) April 16, 1883 6.(c) If alive, give age years8. AGE: Years 62 Months Days If less than one day hrs. min.9. Birthplace Corbanville Pa  
(Town, county, and state)10. Usual occupation Farmer

## 11. Industry or business

12. Name John T. Newlin13. Birthplace Pa.14. Maiden name Oda Hammon15. Birthplace Pa16. Informant R. B. RawlingsAddress Greensboro Md.17. Removal Removal Date thereof 12/11/45  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Holy CrossLocation Deerstown Md.18. Funeral director R. B. RawlingsAddress Greensboro Md.19. 12/8 19 45 N.H. Neerup  
(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH 12-7 19 45, at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/4/45 to 12/7/45 19 45and that I last saw him alive on 12/7/45 19 45

Immediate cause of death

Cerebral hemorrhage

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. E. Cox M. D. or otherAddress Easton Md Date signed 12/8/45

RECEIVED

DEC 26 1945

BUREAU V.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9250

## CERTIFICATE OF DEATH

Reg. Dist. No. 892

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

1945 at 1156A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 24 1945 to Dec. 22 1945

and that I last saw him alive on Dec. 18 1945

Immediate cause of death

heart disease

DURATION

2 yrs.

Due to

arteriosclerosis

12 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED  
DEC 28 1945  
BUREAU A B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH:  
County Talbot  
City or town St. Michaels  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Talbot  
City or town St. Michaels  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME  
Howard Stewart Thomas

3. (b) Social Security Number  
215-12-6206

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan. 16 1902 6.(c) If alive, give age years

8. AGE: Years 43 Months 11 Days 15 If less than one day hrs. min.

9. Birthplace Talbot, St. Michaels, Maryland  
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name Frank Thomas

13. Birthplace St. Michaels, Md.

14. Maiden name Annie Green

15. Birthplace Bellevue, Md.

16. Informant Ester Thomas

Address Baltimore, Md.

17. Burial Date thereof 12 /20/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery

Location St. Michaels, Md.

18. Funeral director J. Norman Marshall

Address St. Michaels, Md.

19. Dec 20 19 45  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION  
20. DATE OF DEATH December 17, 1945 at 11:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 17, 1945 to Dec. 17, 1945 and that I last saw him alive on December 10, 1945

Immediate cause of death  
ACUTE CORONARY DISEASE

Due to Possible Embolic or THROMBOTIC OBSTRUCTION

Due to

Other conditions None

(include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓ Date of ✓

Where did injury occur? ✓  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ✓ Injured at work?

23. SIGNATURE Philip B. Lewis M. D. or other

Address St. Michaels, Md. Date signed 12.18.45

RECEIVED  
JAN 7 1946  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23

## CERTIFICATE OF DEATH

12719

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County Eastern  
 City or town Boston  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death 5 days  
 Hospital, institution, or street address where death occurred:  
Boston Memorial Hospital  
 How long in hospital or institution? 5 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County Prince  
 City or town Boston  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Washington St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Elsie Gordon Tilghman

## 3. (b) Social Security Number

✓

## 4. Sex

F.

## 5. Color or race

W.

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

William Donald Tilghman

## 7. Birth date of

deceased (mo., day, yr.)

March 26, 1888

## 6. (c) If alive, give age

years

## 8. AGE:

Years

Months

Days

If less than one day

59826

hrs.

min.

## 9. Birthplace

Cleveland Ohio

(Town, county, and state)

## 10. Usual occupation

Housekeeper

## 11. Industry or business

At home

## FATHER

## 12. Name

Charles Gordon

## 13. Birthplace

Conn.

## MOTHER

## 14. Maiden name

Mary Augusta Smythe

## 15. Birthplace

Conn.

## 16. Informant

Mr. William Tilghman

## Address

1000 State Boston Md

## 17.

(Burial, cremation, or removal. Which?)

Date thereof

Dec. 24, 1945

(month) (day) (year)

## Cemetery or crematory

St. Mary's

## Location

Just East of

## 18. Funeral director

John J. Smith

## Address

Boston Md

## 19.

(Date rec'd by registrar)

19

45H. H. Harris

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 1945 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 181945 to Dec 221945and that I last saw him alive on Dec 22 1945

Immediate cause of death

Cerebral hemorrhage

DURATION

5 days

Due to

Arteriosclerosisseveral years

Due to

Other conditions

Hypertensive Pneumonia2 days

(Include pregnancy within 3 months of death)

Major findings of operations

no

Date of op.

Autopsy results

no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of 200

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

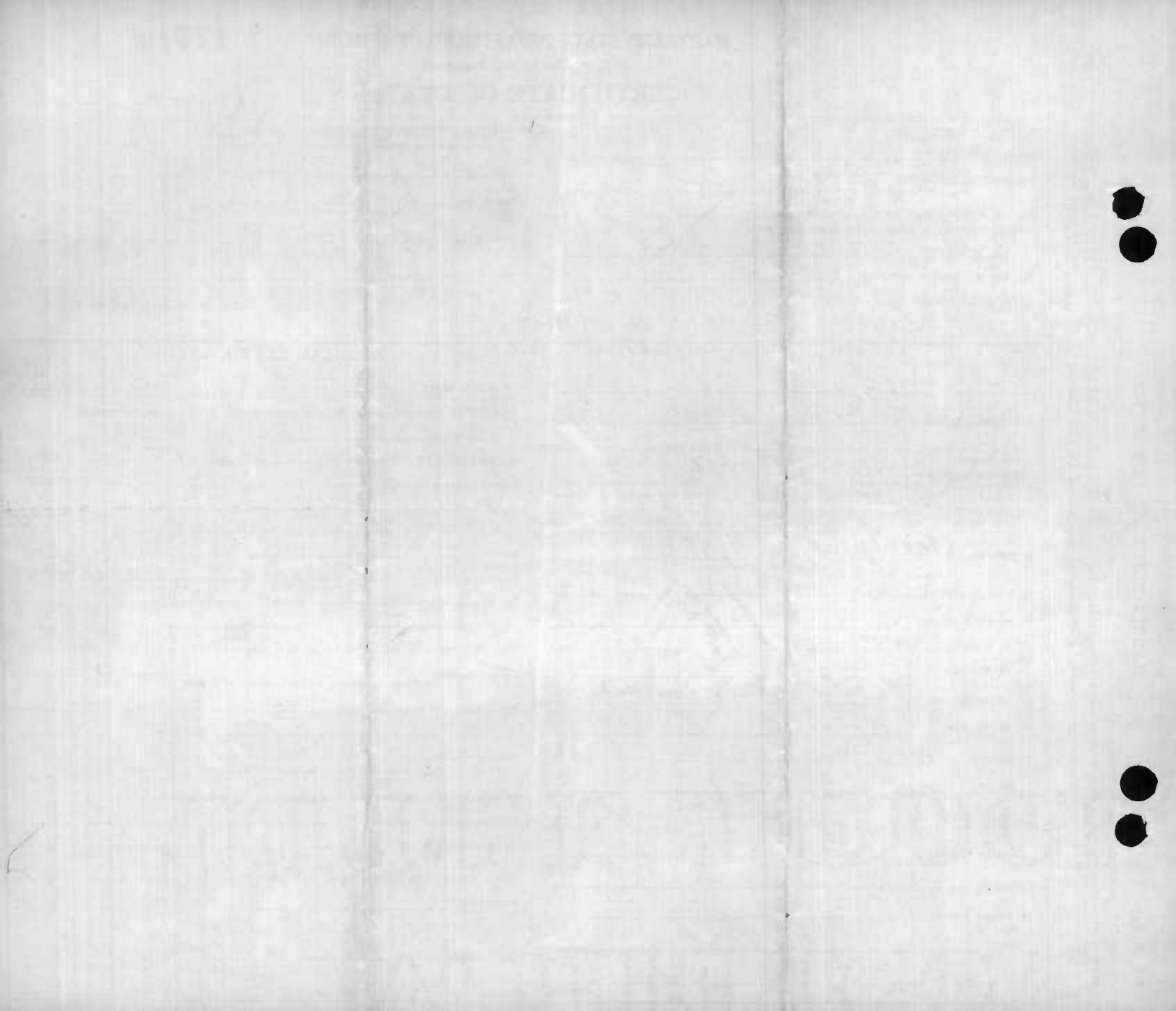
23. SIGNATURE

D. W. C. Stevens M.D.

M. D. or other

Address

Boston MdDate signed 12-28-45





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12720290

## 1. PLACE OF DEATH:

County Talbot  
 City or town Easton, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 13 1/2 hours  
 Hospital, institution, or street address where death occurred:  
Memorial Hospital  
 How long in hospital or institution? 13 1/2 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Caroline  
 City or town Denton, R.D.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION) ✓  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

MAY Bradley Turner

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

F W Married

8. (b) Name of husband or wife H. Kelley Turner7. Birth date of deceased (mo., day, yr.) Nov. 11, 1893 8. (c) If alive, give age 68 years8. AGE: Years Months Days If less than one day  
52 1 16 hrs. min.9. Birthplace Dorchester Co. Md.  
(Town, county, and state)10. Usual occupation H. W.

## 11. Industry or business

FATHER 12. Name George Bradley  
13. Birthplace Dorchester Co. Md.MOTHER 14. Maiden name unknown

15. Birthplace

16. Informant W. Kelley Turner  
Address Denton, Md.17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/29/45  
(month) (day) (year)Cemetery or crematory Concord  
Location Near Federalsburg, Md.18. Funeral director W. H. Hampton & Son  
Address Federalsburg, Maryland19. 12/28 19 45 M. H. Harris  
(Date req'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 19 45 at 1:15 A.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 26 19 45 to Dec 27 19 45 and that I last saw him alive on December 27 19 45Immediate cause of death Cerebral Thrombosis DURATION 48 hrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations NoneAutopsy results Coronary Thrombosis Date of op. \_\_\_\_\_

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide. Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ injured at work? \_\_\_\_\_

23. SIGNATURE R. A. Noble M. D. or other \_\_\_\_\_Address Easton, Md. Date signed 12/29/45

RECEIVED

JAN 3 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

12721

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County TalbotCity or town Easton, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 hrs. 20 min.

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 7 hrs. 20 min.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Easton  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Donald Watson

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single6. (b) Name of husband or wife Lucy M. John Watson7. Birth date of deceased (mo., day, yr.) May 30, 19308. AGE: Years 15 Months 6 Days 29 It less than one day  
hrs. min.9. Birthplace Easton, Md.  
(Town, county, and state)10. Usual occupation School boy

11. Industry or business \_\_\_\_\_

12. Name Mr. John S. Watson13. Birthplace Easton, Md. England14. Maiden name Alice Dorothy Wyatt15. Birthplace Md.16. Informant Mr. John WatsonAddress Easton, Md.17. Burial Date thereof 1/1/46  
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Spring HillLocation Easton, Md.18. Funeral director J. Ellis ClarkAddress Easton, Md.19. 12/30/45 2-11-1945  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 1945 at 4:15 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 22 1945 to Dec. 29 1945and that I last saw him alive on Dec. 29 1945Immediate cause of death Pneumococcus meningitisDURATION 2 daysDue to Grippe 7 days

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE William S. Seymour M. D. or otherAddress Easton Md. Date signed Dec 31/45

RECEIVED

JAN 10 1946

BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 458

## CERTIFICATE OF DEATH

12722

Reg. Dist. No. 290

### 1. PLACE OF DEATH

County Talbot

City or town Easton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital, Easton, Md.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot

City or town Easton  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Emma Wheatley

### 3. (b) Social Security Number

#### 4. Sex

Female

#### 5. Color or race

White

#### 6. (a) Single, married, widowed, or divorced

Single

#### 6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

#### 7. Birth date of deceased (mo., day, yr.)

June 14, 1889

#### 8. AGE:

Years

Months

Days

If less than one day

56

5

21

hrs.

min.

#### 9. Birthplace

Talbot Co. Md.  
(Town, county, and state)

#### 10. Usual occupation

Housekeeper

#### 11. Industry or business

FATHER  
MOTHER

#### 12. Name

Ascanb Wheatley

#### 13. Birthplace

Dorchester Co. Md.

#### 14. Maiden name

Hennetta Alley

#### 15. Birthplace

Talbot Co. Md.

#### 16. Informant

Mrs Bertie Schwaninger

#### Address

Easton Md R.D.

#### 17. Burial

(Burial, cremation, or removal. Which?)

#### Date thereof

12/7/45  
(month) (day) (year)

#### Cemetery or crematory

Landings Creek

#### Location

Trappes Md R.D.

#### 18. Funeral director

Frank E. Monahan Son

#### Address

Easton Md.

#### 19.

12/6

(Date rec'd by registrar)

#### 19.

45

N.B. Meade

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 5 1945 at 8:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 12 1945 to Dec. 5 1945 and that I last saw him alive on December 5 1945

#### Immediate cause of death

Myocardial infarction

#### DURATION

#### Due to

Cu of Myo-phosphorus

2 yrs.

#### Due to

#### Other conditions

(Include pregnancy within 8 months of death)

#### Major findings of operations

Date of op. \_\_\_\_\_

#### Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

#### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. \_\_\_\_\_ Date of \_\_\_\_\_

#### Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

#### Means of injury

Injured at work?

#### 23. SIGNATURE

J. Lynn Baker M.D.

M. D. or other

#### Address

Date signed \_\_\_\_\_

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 26 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 982

## CERTIFICATE OF DEATH

12723

Reg. Dist. No. 292

## 1. PLACE OF DEATH:

County TALBOT  
 City or town TRAPPE (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 60 days  
 Hospital, institution, or street address where death occurred  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County Talbot  
 City or town Trappe rural (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

MAGGIE KATHRYN WILLSON

## 3. (b) Social Security Number

4. Sex

female

5. Color or race

C

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Walter Wilson

7. Birth date of deceased (mo., day, yr.)

Nov. 20, 1884

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

61

20

hrs.

min.

9. Birthplace

TALBOT Co., Md.  
(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

12. Name

JOSEPH WILLSON

13. Birthplace

TRAPPE, TALBOT Co., Md.

14. Maiden name

SADDIE WILLSON

15. Birthplace

TRAPPE, TALBOT Co., Md.

16. Informant

Saddie Willson

Address

Trappe, Md. Rd.

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

Dec. 13, 1945

Cemetery or crematory

Trappe, Talbot Co., Md.

Location

Carl W. Stafford

19. Funeral director

Carter, Md.

Address

Dec 13 1945

Date rec'd by registrar

19 45

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 10 - 1945 at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 29 1945 - Dec 10 - 1945

and that I last saw him alive on Dec 9 - 1945

Immediate cause of death

Cardiac decompensation

Due to

Chronic myocarditis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Joseph Willson

Address

Trappe Md

Data signed

M. D. 12/14/45



UNITED STATES DEPARTMENT OF JUSTICE

CRIMINAL DIVISION

RECEIVED

DEC 17 1945

BUREAU V.B.